STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

PREMIER BEHAVIORAL SERVICES OF TENNESSEE, LLC

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2004
THROUGH JUNE 30, 2004

TABLE OF CONTENTS

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
TENNCARE DIVISION
615-741-2677 Phone
615-532-8872 Fax
500 JAMES ROBERTSON PARKWAY, SUITE 750
NASHVILLE, TENNESSEE 37243-1169

TO: J.D. Hickey, Deputy Commissioner
Tennessee Department of Finance and Administration, TennCare Bureau

Paula A. Flowers, Commissioner
Tennessee Department of Commerce and Insurance

Virginia Trotter Betts, Commissioner
Tennessee Department of Mental Health and Developmental Disabilities

VIA: Gregg Hawkins, CPA, Assistant Director
Office of the Comptroller of the Treasury
Division of State Audit

Lisa R. Jordan, CPA, Assistant Commissioner
Tennessee Department of Commerce and Insurance

John Mattingly, CPA, TennCare Examinations Director
Tennessee Department of Commerce and Insurance

CC: Dave Goetz, Commissioner
Tennessee Department of Finance and Administration

FROM: Gregory Hawkins, CPA, TennCare Examinations Manager
Laurel Hunter, CPA, TennCare Examiner
Robin Lowe, CPA, CFE, TennCare Examiner
Karen Degges, Legislative Auditor
Jacqueline Laws, Legislative Auditor

DATE: November 28, 2005

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Premier Behavioral Systems of Tennessee, LLC, Nashville, Tennessee, was completed April 18, 2005. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of Premier Behavioral Systems of Tennessee, LLC, (Premier). Further, this report reflects the results of a limited scope examination of the financial statement account balances as reported by Premier. This report also reflects the results of a compliance examination of Premier's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authorization of Section 3.12.10, 3.13.1, and 3.14.3 of the TennCare Partners Provider Risk contract between the State of Tennessee and the BHOs and Tennessee Code Annotated Sections 56-51-132, 56-32-215, and 56-32-232.

Premier is licensed as a prepaid limited health services organization (PLHSO) in the state and participates by contract with the state as a behavioral health organization (BHO) in the TennCare Partners Program. The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) is responsible for administration of the TennCare Partners Program. TDMHDD and the Bureau of TennCare are responsible for verifying the eligibility of participants and for assigning them to and disenrolling them from the TennCare Partners Program.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of Premier. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statements as reported by Premier on its

National Association of Insurance Commissioners (NAIC) quarterly statement for the period ended June 30, 2004, and the Medical Loss Ratio Report for the period ended June 30, 2004.

The limited scope compliance examination focused on Premier's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with Federal Title VI of the 1964 Civil Rights Act and the Insurance Holding Company Act.

Fieldwork was performed using records provided by Premier before and during the onsite examination, at the Nashville, Tennessee, office from October 4, 2004, through April 18, 2005.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that Premier's TennCare operations were administered in accordance with the Provider Risk Agreement, and state statutes and regulations concerning PLSHO operations, thus reasonably assuring that the Premier TennCare members received uninterrupted delivery of mental health and substance abuse services on an ongoing basis.

The objectives of the examination were to:

- Determine whether Premier met certain contractual obligations under the Provider Risk Agreement and whether Premier was in compliance with the regulatory requirements for PLSHOs set forth in Tenn. Code Ann. § 56-51-101 *et seq.* and Tenn. Code Ann. § 56-11-201 *et seq.*;

- Determine whether Premier had sufficient financial capital and surplus to ensure the uninterrupted delivery of mental health and substance abuse services for its members on an ongoing basis;

- Determine whether Premier properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether Premier had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner, and

- Determine whether Premier had corrected deficiencies outlined in prior examinations by the Comptroller or TDCI.

III. PROFILE

A. Brief Overview

The TennCare Partners Program, a managed care capitation program for mental health and substance abuse services, was initiated on July 1, 1996, and is designed to function in a manner similar to the TennCare Program. TennCare replaced the existing Medicaid Program on January 1, 1994, with a program of managed health care providing traditional medical services. Prior to July 1, 1996, mental health and substance abuse services were generally funded by grants or fee-for-service payments from the state. Although some grant payments, such as contracts with the Department of Children's Services, to the community mental health centers are unaffected by the TennCare Partners Program, funding for most of the services has shifted to the TennCare Partners Program. Each month, the state pays a capitation rate for each TennCare Partners Program participant to one of the two managed care organizations, referred to as behavioral health organizations, that contract with the state to provide mental health and substance abuse services. The BHOs are Premier and Tennessee Behavioral Health, Inc. (TBH).

Premier is licensed and regulated by TDCI as a PLSHO pursuant to Tenn. Code Ann. § 56-51-101 *et seq.* TDCI issued Premier a certificate of authority to operate as a PLHSO on November 19, 2003.

The assignment of TennCare Partners Program participants to the two BHOs is based upon the participants' enrollment in the TennCare managed care organizations. There were approximately 896,687 Premier participants as of June 30, 2004. During the examination period, the managed care organizations and their assigned participants to Premier were as follows:

- Volunteer State Health Plan, Inc. d/b/a BlueCare and TennCare Select
- Better Health Plans
- John Deere Health Plan, Inc.
- UAHC Health Plan of Tennessee, Inc. (Formerly OmniCare Health Plan, Inc.)
- Windsor Health Plan of TN, Inc. (Formerly Victory Health Plan, Inc.)

The remaining managed care organizations' enrollments, approximately 434,833 participants, were assigned to TBH.

There are two categories of participants in the TennCare Partners Program: priority participants and basic participants. Priority participants include individuals diagnosed as severely and/or persistently mentally ill (SPMI) aged 18 years or older and individuals under the age of 18 diagnosed as having severe emotional disturbance (SED). TennCare Partners participants who are not priority participants are referred to as basic participants. Services covered for both the priority and basic participants include inpatient psychiatric hospitalization, outpatient mental health services, substance abuse treatment, psychiatric pharmacy and lab-related services, transportation to mental health and substance abuse services, and specialized crisis services. Additional services covered for the priority population includes mental health case management, 24-hour residential treatment, housing/residential care, specialized outpatient and symptom management, and psychiatric rehabilitation services.

An additional category of individuals for which mental health and substance abuse services are covered by the BHOs is judicials. These individuals are not considered enrollees or participants in the BHO plan but are entitled to coverage for services required by the statute or court order under which the individual was referred.

B. Administrative Organization of Premier

Premier Behavioral Systems of Tennessee, LLC, was organized in May 1996 and owned by Premier Holdings, Inc., a wholly-owned subsidiary of Magellan Health Services (Magellan), and Columbia Behavioral Health, LLC, ultimately a wholly-owned subsidiary of HCA, Inc., for the purpose of contracting with the State of Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) to deliver mental health and substance abuse services to the TennCare Partners Program. On January 5, 2004, Onex Corporation, Toronto, Canada, acquired a 24% ownership interest in Magellan and became the ultimate controlling entity.

Premier contracts with AdvoCare of Tennessee, Inc., also a wholly-owned subsidiary of Magellan, to manage the operations, administrative services and clinical services related to provision of all mental health benefits, to provide case management services and to arrange primary care and outpatient services.

The officers and board of directors for Premier at June 30, 2004, were as follows:

Officers for Premier

Rene Lerer, President
Russell C Petrella, Senior Vice President – Public Solutions
William R. Grimm, Vice President – Public Solutions

Board of Directors for Premier

William Grimm	Sandy Butters	Rene Lerer
Russell C. Petrella	Russell Harms	Tim Scarvey

C. Provider Contracts and Subcontracts

The contract between TDMHDD and Premier requires that Premier maintain a sufficient network of hospital providers with the capability of providing the benefits required under the contract. The contract also requires Premier to maintain a sufficient inpatient provider network, so no inpatient provider, especially the regional mental health institutes, is forced to exceed licensed capacity. Premier contracts with the State of Tennessee's five regional mental health institutes. These institutes provide essential inpatient mental health services to the priority population. Premier has contracted with the regional mental health institutes on a per diem basis. Inpatient, intensive outpatient, and partial hospitalization services are also provided by hospitals across Tennessee on a per diem basis.

In addition, the contract encourages Premier to contract with community mental health centers (CMHCs). The primary providers of outpatient mental health services for the priority population are the CMHCs located across the state. The CMHCs act as care coordinators responsible for arranging the behavioral health care needs of their assigned participants. Premier compensates the CMHCs with monthly case rates payments per SPMI participant. The case rate payment is based on tiered levels determined by the average number of case management encounters the CMHC provides. The CMHC case rate payments are adjudicated through an internal claims processing system developed by AdvoCare. The 22 CMHCs send AdvoCare

monthly electronic files that contain the claims information that is required on a standard physician medical claim form. AdvoCare sends interim monthly payments to the CMHCs which are ultimately reconciled to adjudicated claims data.

Other providers such as physicians, psychiatrists, licensed social workers, and hospitals are paid through a subcontracted claim processor based upon a fee schedule or per diem. During the period under examination, Magellan subcontracted with Affiliated Computer Services, Inc. (ACS) for processing and paying claims submitted by providers with the exception of CMHC providers.

Effective July 1, 1998, the State assumed financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees in the TennCare Partners Program.

D. Subsequent Event

Effective July 1, 2004, Premier's enrollment decreased to approximately 625,000. The enrollment decrease was because an additional contract was entered into between the State and the other BHO, TBH, to provide services for most of the recipients in the East Grand region of the State.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are set forth for informational purposes. The following were financial and claims processing deficiencies cited in the examination by the Comptroller of the Treasury, Division of State Audit, and the Tennessee Department of Commerce and Insurance, TennCare Division, for the period July 1, 1998, through June 30, 2000:

A. Financial

1. Premier did not provide the examiners with requested information, specifically the general ledgers of an affiliate, which support the allocation of administrative expenses on the NAIC Financial Statements.

2. Premier understated incurred but not reported (IBNR) claims expense at June 30, 2000. TDCI non-admitted unsupported health care receivables. Both items resulted in Premier's June 30, 2000 net worth being overstated and adjusted by TDCI.

None of the deficiencies listed above are repeated as part of this report.

B. Claims Processing System

1. Premier incorrectly paid nine (9) of sixty (60) claims reviewed.

2. Premier improperly denied three (3) of sixty (60) claims reviewed.

3. Premier inadequately reported encounter data required by the TennCare Partners contract. The encounter data did not include all revenue, procedure, and diagnosis codes.

4. Of fifty-one (51) Regional Mental Health Institute claims reviewed, Premier incorrectly paid fifteen (15) claims.

5. Of fifty-one (51) Regional Mental Health Institute claims reviewed, Premier improperly denied twenty-nine (29) claims.

6. Premier is not in compliance with Tennessee Code Annotated (T.C.A.) § 56-32-226(b) requirements for timely adjudication of claims.

None of the deficiencies listed above are repeated as part of this report.

C. Other Deficiencies

1. Premier did not include in the provider agreements all the required language specified by Section 3.9.2 of the TennCare Partners contract.

The deficiency listed above is not repeated as part of this report.

V. SUMMARY OF CURRENT FINDINGS

The summaries of current factual findings are set forth below. The details of testing as well as management's comment to each finding can be found in Sections VI, VII and VIII of this examination report.

A. Financial Analysis

1. Premier should improve the methodology utilized for the allocation of management fees to expense categories on the NAIC financial

statements by initially identifying salaries and compensation incurred by the management company which are 100% related to Premier or other affiliates. Salaries and compensation that are related 100% to a plan should be allocated to the specific plan before other pertinent ratios are applied. Any change to the methodology will not affect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expense on NAIC financial statements. (See Section VI.A.3.)

B. Claims Processing System

1. The April 2004 claims data file submitted by Premier for TDCI to test prompt pay requirements erroneously included a behavioral health claim that was paid by TBH. (See Section VII.A.)

2. The sampling methods to determine the claims payment accuracy percentages reported by Premier to TDMHDD were inadequate. Premier failed to include in the test population all claims processed by Premier and the claims processing subcontractor. (See Section VII.C.1.)

3. From the 30 fee-for-service claims selected for testing, two claims had keying errors of information reported on the hard copy claim. (See Section VII. E.)

4. One fee-for-service claim was denied incorrectly by Premier for the denial reasons of member was not on file and the date of birth could not be matched. (See Section VII.F.)

5. Premier does not load copayment accumulator files from the TennCare Bureau into their claims processing system. Without the consideration of the copayment accumulators from TennCare, Premier could continue to apply copays even if the enrollees have exceeded their annual out-of-pocket maximum. (See Section VII. H.)

C. Compliance Testing

1. Premier did not provide written policies and procedures to process provider complaints. (See Section VIII. A.)

2. One provider complaint tested was not responded to within the 30 day standard utilized by Premier. (See Section VIII. A.)

3. For two provider complaints tested, the response date reported on the complaint log did not agree with the response date on the supporting documentation. (See Section VIII. A.)

4. The subcontract between Magellan and ACS for claims processing is non-compliant at the report date due to changes in the subcontract requirements of the TennCare Partners Provider Risk Agreement. (See Section VIII. D.)

5. Premier did not submit to TDCI, for required prior approval, the service agreements which represent a material modifications to Premier's application for certificate of authority pursuant to Tenn. Code Ann. § 56-51-108. (See Section VIII.F.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

Premier is required to file annual and quarterly financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed in these reports to determine if Premier meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2004, Premier reported $51,742,678 in admitted assets, $41,019,062 in liabilities and $10,723,616 in capital and surplus on its NAIC statement. Premier reported net income of $596,669 on its statement of revenue and expenses as of June 30, 2004.

1. Capital and Surplus

Tenn. Code Ann. § 56-51-136 requires PLHSO to establish and maintain statutory financial reserves as calculated pursuant to Tenn. Code Ann. § 56-32-212.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan." Based on this definition, all TennCare payments made to a licensed PLHSO such as Premier are included in the calculation of net worth and restricted deposit requirements.

2004 Net Statutory Net Worth Calculation

Tenn. Code Ann. states that the minimum net worth requirement shall be equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150,000,000 of revenue earned for the prior calendar year, plus 1.5% of the amounts earned in excess of $150,000,000 for the prior calendar year. Premier's premium revenue per documentation obtained from the TennCare Bureau totaled $280,720,698 for the calendar year 2003; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), Premier's minimum statutory net worth requirement based on 2003 revenue is $7,960,810. Premier reported total capital and surplus of $10,723,616 as of June 30, 2004, which is $2,762,806 in excess of the minimum net worth requirement.

Premium Revenue for the Examination Period

For the examination period Premier was under a risk banding agreement with the State. The risk banding agreement allows 100% of losses related only to medical expense beyond the monthly capitation paid to be covered by the State. Administrative expenses other than premium taxes are limited to 10% of monthly capitation payment in the risk share calculation. For the examination period January 1 through June 30, 2004, Premier's premium revenue as defined by Tenn. Code Ann. § 56-51-136 and § 56-32-212(a)(2) is:

Net Premium Income	$ 132,353,449
Risk Share Revenue	13,775,726
ASO Revenue (See Section VI.A.4.)	390,000
Total premium revenue January 1 through June 30, 2004	$146,519,175

2. Restricted Deposit

Tenn. Code Ann. § 56-51-136, § 56-32-212(b)(2) and § 56-32-212(b)(3) require all licensed PLSHOs to maintain a deposit equal to $900,000, plus an additional $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan."

Based upon premium revenues for calendar year 2003 totaling $280,720,698, Premier's statutory deposit requirement at December 31, 2003, is $2,650,000; however, since May 1999, Premier has been required to maintain an enhanced restricted deposit of $3,320,000. Premier has on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $3,320,000 have been pledged for the protection of the enrollees in the State of Tennessee.

3. Management Agreement and Administrative Expense Allocations

Premier contracts with AdvoCare of Tennessee, Inc. (AdvoCare), a wholly-owned subsidiary of Magellan Health Services, Inc., to manage the operations, to provide administrative services and clinical services related

to the provision of all mental health benefits, to provide case management services and to arrange primary care and outpatient mental health services. AdvoCare contracts with outpatient mental health service providers directly on behalf of both Premier and TBH. AdvoCare reimburses outpatient mental health service providers utilizing payment methodologies including case rates, based primarily on level of services provided and the number of service encounters of such services. The cost of these services are allocated by AdvoCare to Premier and TBH using methods AdvoCare considered reasonable and that reflected utilization of services provided to Premier members. These methods include proportionate formulas based on monthly membership counts of both BHOs and other encounter data.

For NAIC financial statement reporting, the management fee must be apportioned to the administrative expense categories defined on NAIC annual and quarterly financial statements. The NAIC 2004 Health Quarterly and Annual Statement Instructions require that an HMO that has paid management fees to an affiliated entity "shall allocate these costs to the appropriate expense classification item (salaries, rent, postage, etc.) as if these costs had been born directly by the company…The reporting entity may estimate these expense allocations based on a formula or other reasonable basis."

The NAIC's Statement of Statutory Accounting Principles No. 70 requires where entities operate within a group where personnel and facilities are shared, the shared expenses should be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Specific identification of an expense with an activity that is represented by one of the categories will generally be the most accurate method. Where specific identification is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, premium ratios, or similar analysis.

For allocating the management fee paid by Premier to Advocare to expense classifications on the Underwriting and Investment Exhibit – Part 3 of the NAIC Annual Statement, Premier used allocation percentages derived from some of the administrative expenses categories on the Advocare trial balance. The allocation method failed to first specifically identify expenses incurred for the benefit of Premier by Advocare. The

allocation method utilized by Premier incorrectly assumes that all companies will incur administrative expenses at the same ratio. Additionally, the method utilized by Advocare only allocates administrative expenses incurred by Advocare but none incurred by Magellan on behalf of Premier.

Premier should review its methodology for the apportioning of management fees to NAIC administrative expense classifications and categories. As discussed in the NAIC 2004 Health Quarterly and Annual Statement Instructions and Statutory Accounting Principle No. 70, Premier should allocate management fees to expense classifications as if these costs had been borne by Premier itself and to then allocate expenses to administrative categories first by specific identification. If specific identification is not possible, then allocation based on pertinent factors or ratios is acceptable. Administrative expenses incurred by both Advocare and Magellan should be considered. Documentation should be maintained to support that the allocation methodology is reasonable and yields the most accurate results.

MANAGEMENT'S COMMENTS

Management feels that the allocation methodology it has chosen is consistent with the guidelines outlined in NAIC Statement of Statutory Accounting Principles No. 70. Premier will reevaluate its allocation methodology and include Magellan costs, appropriately allocated by expense line item. Premier will perform this activity during the 4th quarter of 2005 and implement the suggested changes with the 2005 annual report due in March 2006.

4. Claims Payable

As part of the NAIC Statement filing requirements, Premier is required to provide a statement of actuarial opinion. This statement expresses an opinion on whether the claims payable reported by the BHO is adequate to cover all future obligations. This statement must be prepared by a member of the American Academy of Actuaries. Premier's statement was prepared by Ernst & Young, LLP, and met all the requirements established by the NAIC. The actuarial statement supported a claims payable amount of $20,910,823 as of June 30, 2004. This amount agreed with the amount reported on the NAIC balance sheet as "Claims Unpaid."

5. Third Party Liability Recoveries

Section 3.15.7 of the Provider Risk Agreement states third party liability recoveries will be treated as offsets to claims expense. Premier makes the adjustment for the recovered amount to the actual claim involved in the recovery. The amount is recorded as a reduction of medical expense.

B. Administrative Services Only (ASO)

Per Premier's Provider Risk Agreement an administrative fee of $65,000 per month is paid to Premier to administer additional services for children in state custody. Premier appropriately reported $390,000 of ASO income on the TennCare Operations Statement of Revenue and Expenses, Report 2A.

C. Medical Loss Ratio

Effective June 7, 2001, the Provider Risk Agreement requires Premier to submit a Medical Loss Ratio (MLR) report monthly. The MLR accounts for medical payments and incurred but not reported (IBNR) claims expense based upon month of service. Premier submitted monthly MLR reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MLR estimates for IBNR expenses have been reviewed for accuracy.

No discrepancies were noted during the review of documentation supporting the amounts reported on the MLR reports.

D. Schedule of Examination Adjustments to Capital and Surplus

There were no examination adjustments to capital and surplus.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether Premier pays claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1), and section 3.13.2 of the Provider Risk Agreement. The statute mandates the following prompt pay requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> (A) "Pay" means that the health maintenance organization shall either send the provider cash of cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
>
> (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reason for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI previously requested data files from Premier containing all claims processed during the months of January 2004 and April 2004. The dates of services of claims processed during these two months are of the most relevance to the examination period. Each set of data was tested in its entirety for compliance with the prompt pay requirements of Tenn. Code Ann. § 56-32-226. Because these tests were performed on all claims processed in January 2004 and April 2004, no projection of results to the population is necessary. Listed below are the results of these analyses:

	Within 30 days	Within 60 days	Compliance

T.C.A. Requirement	90%	99.5%	
April 2004	99%	100.0%	**Yes**
July 2004	100%	99.9%	**Yes**

Premier processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements in the months of January 2004 and April 2004.

Issue Identified with Prompt Pay Data File Submission

The April 2004 claims data file submitted by Premier for TDCI to test prompt pay requirements erroneously included two behavioral health claim that were paid by TBH. Premier should ensure that the prompt pay data file submissions appropriately include only Premier processed claims.

MANAGEMENT'S COMMENTS

Premier will review claims files before submission to ensure that prompt pay data files include only claims processed by Premier.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of test work to be performed in the testing of Premier's claims processing system.

The following items were reviewed to determine the risk that Premier had not properly processed claims:

- Complaints on file with TDCI related to accurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy report submitted to TDCI and TDMHDD
- Review of the preparation of the claims payment accuracy report
- Review of internal controls

There were significant weaknesses found in the preparation of the claims payment accuracy report, thus substantive tests were increased as discussed below in Section VII.C.

C. Claims Payment Accuracy Report

Section 3.12.14 of the Provider Risk Agreement requires that performance measurements shall be submitted to TDMHDD in accordance with Attachment E. Attachment E section I.2 requires that 97% of claims are paid accurately upon initial submission. Premier is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

1. Procedures to Review Claims Payment Accuracy Reporting

The review of the claims payment accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the monthly reports for July, August, and September 2004. For testing purposes, these months are of the most relevance to the examination period because of the lag between the date of service and the received and processed date of CMHC claims.

Tests Performed for Fee-For-Service Claims

Evaluation of the test performed by Magellan indicates that a 2% randomized sample of completed fee-for-service claims for claims processed by the claims processing subcontractor, ACS, is audited. A detailed matrix of the audit database attributes tested was also reviewed.

Tests Performed for CHMC Case Rate Claims

CMHC case rate claims processed by the internal claims processing system were not included in the claims payment accuracy testing by Magellan. All claims should be included in the population for evaluation and reporting of claims payment accuracy requirements of Section 3.12.14 of the Provider Risk Agreement. As a result, claims payment accuracy percentages previously reported by Premier do not accurately reflect the claims payment accuracy percentages actually achieved by Premier. In order to gain confidence in the payment accuracy levels for CMHC case rate claims payments, TDCI expanded testing of CMHC case rate payments as discussed below in Section VII.D.

MANAGEMENT'S COMMENTS

Pursuant to this finding, Premier added the CMHC case rate claims to the claims payment accuracy testing beginning November 2004.

2. Results of Review of the Claims Payment Accuracy Reporting

The number of claims tested and the methodology used to test the fee-for-service claims appears adequate.

Two CMHCs were judgmentally selected for testing by TDCI and the Comptroller to verify Premier's calculation of CMHC payments. The claims data for one month was examined for each CMHC to determine adjudication accuracy and to recalculate the case rate payment for that month. No deficiencies were noted in either the testing performed by Magellan on only the ACS claims or the alternative testing performed by TDCI on the CMHC claims.

D. Claims Selected For Testing

Sixty claims were selected for testing. For previous prompt pay testing by TDCI, Premier had provided a data file of paid and denied claims for the month of April 2004. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance within the total population of claims.

To ensure that the April 2004 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags. As part of the examination, the triangle lags were reconciled to the general ledger for the six month period to within an acceptable level.

Of the 60 claims selected for testing, 30 were fee-for-service claims processed through the ACS claims processing system. The remaining 30 were CMHC case rate claims designated as capitated claims in the data file and were not processed in the ACS system.

As previously noted, TDCI and the Comptroller expanded testing for CMHC claims since Premier failed to include CMHC claims in the claims payment accuracy reporting test work. In lieu of performing attribute testing on the CMHC claims, alternative test procedures were performed by TDCI as follows:

- Analyzed the case rate system to develop an understanding of the case rate payment process from initial submission of the claim data from the CMHC to the final adjudication payment made by Premier;

- Selected two (2) CMHCs, and examined each CMHC's data from one month for adjudication accuracy and recalculated the case rate payment for that month;

- Determined if the encounter data submitted to the TennCare Bureau contains denied CMHC claims; and

- Determined if data files submitted for prompt pay contain denied CMHC claims.

Ten enrollees were selected from each CMHC and the encounters/claims for the twenty enrollees were examined. No deficiencies were noted during the expanded test work of processed CMHC claims.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in the claims processing system. Attachment D of the Provider Risk Agreement lists the minimum required data elements to be captured from claims and reported to TennCare as encounter data.

Original hard copy claims were requested for the 30 fee-for-service claims selected for testing from the ACS claims processing system. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested and reviewed. The data elements of Attachment D recorded on the claims selected were compared to the data elements entered into Premier's claims processing system.

Additionally, for the 20 enrollees selected from the CMHC system, claim information submitted by the CMHC to the BHO was compared with the encounter data reported to TennCare.

From the 30 fee-for-service claims selected for testing, two claims had keying errors. On one claim the second diagnosis code and the date of service were not entered into the system. On the other claim the first line of service amount was not entered into the system. No discrepancies were noted in the CMHC testing.

MANAGEMENT'S COMMENTS

Magellan meets with the claims vendor weekly in order to review keying patterns and/or scanning errors. Magellan works with the claims vendor to develop/implement corrective actions.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected.

One fee-for-service claim was denied incorrectly by Premier for the denial reasons of member was not on file and the date of birth could not be matched.

MANAGEMENT'S COMMENTS

Premier staff will work with the examiner and a claims specialist Jackie Kline to research claim incorrectly denied. Prior to review of the specific claim, claim staff suggested that the issue of retroactive eligibility may contribute to this uncommon occurrence. Upon review, we will share our findings and any corrective action, if needed.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

For the 30 fee-for-service claims selected for testing, no discrepancies were noted. Also, there were no discrepancies noted in the case rate payment methodology.

H. Copayment Testing

The purpose of testing copayments is to determine if the copayments for enrollees subject to out-of-pocket payments for certain procedures are accurately calculated in accordance with section 3.4.4 of the Provider Risk Agreement.

TDCI requested a list of the top 100 enrollees with the highest dollar amount of copayments applied. The copayment amounts for five Premier enrollees were compared to the copayment information in the ACS (fee-for-service) claims processing system.

Premier does not load copayment accumulator files from the TennCare Bureau into either the fee-for-service or the CMHC claims processing systems; therefore, TDCI could not determine if the enrollees exceeded their maximum out-of-pocket payment liability. Without consideration of the copayment accumulators from TennCare, Premier could continue to apply copayments even when an enrollee has exceeded his/her annual out-of-pocket maximum.

MANAGEMENT'S COMMENTS

Copayment accumulator routines are being rewritten in connection with TennCare Reform benefit limits to be effective January 1, 2006.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to the provider accurately reflect the processed claim information in the system.

The remittance advices for eleven of the fee-for-service claims selected for testing were obtained to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between payment information in the claims processing system and the information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to verify the actual payment of claims by Premier and determine whether a pattern of significant lag times

exists between the issue date and the cleared date on the checks examined.

The cancelled checks for the five claims tested were requested. The check amounts agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended Claims

The purpose of testing pended claims is to determine the existence of claims that have been suspended or pended by Premier, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. Premier provided the examiners a pended claims report as of April 30, 2004. Premier reported a total of 272 pended claims of which 48 were over 60 days old. The review of the pend file does not indicate a potential material unrecorded liability.

L. Electronic Claims Capability

Section 3.13.2 of the Provider Risk Agreement states, “The Contractor shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically.” The electronic billing of claims allows the BHO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (“HIPAA”) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

Premier has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes. Premier is currently processing claims under these standards for some providers.

M. Mailroom Testing and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures followed by Premier ensure that all claims received

from providers are either returned to providers where appropriate or processed by the claims processing system. The review of mailroom and claims inventory internal control questionnaire section provided assurance that mailroom inventory controls are adequate.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

The purpose for testing provider complaints is to determine if Premier has developed adequate procedures to ensure provider complaints are responded to in a timely manner. Premier personnel provided the examiners with policies and procedures related to appeals. In review of the documents, it was noted that the procedures only specifically address enrollee appeals and inquiries; however, Premier personnel indicated that they apply the enrollee appeals policy to provider complaints. The written policy for enrollee appeals required that all inquiries/complaints be responded to within 30 days.

Ten complaints were judgmentally selected for testing from the 2004 complaint log maintained by Premier.

The following deficiencies were noted during review of provider complaints:

- Premier did not provide written policies and procedures to process provider complaints.

- For two of the ten complaints, the response date reported on the provider complaint log did not agree with the response date indicated on documentation supporting the complaint.

- One provider complaint tested was not responded to within the 30 day standard utilized by Premier.

MANAGEMENT'S COMMENTS

Premier will provide policy CR.1103.03, Provider Performance Inquiry and Review Policies and Standards to TDCI for review. Appeals oversight will continue to review/monitor complaints for consistency and accuracy.

B. Provider Manual

The provider manual outlines written guidelines for providers that include, but are not limited to, requirements for obtaining authorization to provide certain treatments to enrollees and for submitting claims for payment. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

Premier's provider agreements reference Premier's provider manual for written guidelines as it pertains to standards for care, utilization review/quality improvement, claims processing and other procedural requirements. These references incorporate the provider manual into the provider agreements, and therefore the provider manual requires prior approval in accordance with Tenn. Code Ann. § 56-51-108.

Premier has submitted its provider manual to TDCI and has received approval.

C. Provider Agreements

Agreements between a PLSHO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an PLSHO as provided by Tenn. Code Ann. § 56-51-106(6). A licensed PLSHO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-51-108. Additionally, TDMHDD has defined through contract with Premier minimum language requirements to be contained in the agreements between Premier and its contracted providers. These minimum contract language requirements, include but are not limited to; standards of care, assurance of TennCare enrollees rights, compliance with all Federal and State laws and regulations, and prompt and accurate claims payment.

Per Section 3.9.2 of the Provider Risk Agreement between Premier and TDMHDD, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an

PLSHO's certificate of authority and any material modification thereof. Additionally, Section 3.9.2. of the Provider Risk Agreement requires that all provider agreements executed by Premier shall at a minimum meet the current requirements listed in Section 3.9.2. of the Provider Risk Agreement.

Four (4) provider agreements related to claims selected for testing were reviewed to determine if they contained all the minimum language requirements of Section 3.9.2 of the Provider Risk Agreement. All four agreements met the minimum language requirements of Section 3.9.2 as of June 30, 2004.

D. Subcontracts

During the examination period, ACS was subcontracted by Magellan to provide claims processing service. The subcontract between Premier and ACS for claims processing was reviewed for compliance and found to be in compliance at the exam date of June 30, 2004; however, the contract is non-compliant at the report date due to changes in the TennCare Partners Provider Risk Agreement that have not been incorporated into the subcontract. The subcontract should be updated to include language related to the following Provider Risk Agreement provisions:

- Section 3.1.12 Fraud and Abuse
- Section 3.7.1.6 HIPAA Requirements
- Section 6.15.1 Debarment and Suspension
- Section 6.5.2 Bid Proposals
- Section 3.7.2.25 Indemnification
- Section 3.7.1.9 Revoking Delegation
- Section 1-8 Third Party Beneficiaries
- Section 3.1.12.2.5 Display Signs.

MANAGEMENT'S COMMENTS

An AdvoCare staff member and Magellan legal staff are working to draft an administrative amendment to the ACS subcontract in order to implement the above referenced changes. Once updated, the subcontract will be submitted for review/approval.

E. Title VI

Effective July 1996, Section 3.17 of the Provider Risk Agreement required Premier to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Premier was in compliance with Section 3.17 of the Provider Risk Agreement.

F. Subsequent Event

Effective July 1, 2004, the Service Agreement between Premier and AdvoCare was amended from a per member per month fee to instead pay a 9% administrative fee based on fees payable by the State of Tennessee. Additionally, the service agreement between Premier and Columbia was amended from a per member per month fee to instead pay a fixed fee of $90,000 per month. Premier did not submit the amendments to the service agreements for approval to TDCI as material modifications to its application for certificate of authority.

Tenn. Code Ann. § 56-51-108 requires that in order to maintain its eligibility for a certificate of authority, a PLHSO must continue to meet all conditions required to be met under §§ 56-51-106 and 56-51-107 for application and issuance of its certificate of authority. Tenn. Code Ann. § 56-51-106(1) requires a copy of the applicant's basic organization documents. The administrative service agreements between Premier and AdvoCare and Premier and Columbia are basic organizational documents.

MANAGEMENT'S COMMENTS

Premier has submitted the proper documentation necessary for a material modification to the certificate of authority as it relates to the service agreements between Premier and AdvoCare and between Premier and Columbia.

TDCI REBUTTAL

The material modification to the certificate of authority as it relates to the service agreements between Premier and AdvoCare and between Premier and Columbia was submitted to TDCI for approval with the management's comments to this examination report on October 26, 2005. Premier is again reminded to consider the prior approval requirements of Tenn. Code Ann. § 56-51-108 before executing or altering basic organization documents of the company.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of Premier.